IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-035177
STATE FILE NUMBER

FILED VS SEP 27 1960 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 459

VIDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence
Length of stay in 1b: 83 Yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Independence
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 610 So. Noland
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First OLIVER Middle A Last Turner
4. DATE OF DEATH: Month 9 Day 20 Year k960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1 19 1877
9. AGE (last birthday): 83
IF UNDER 1 YEAR Months Days; IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Mgr.
10b. KIND OF BUSINESS OR INDUSTRY: Theater
11. BIRTHPLACE (City and state or country): Wayne City, Missouri
12. CITIZEN OF WHAT COUNTRY: U. S. A
13a. FATHER'S NAME: Robert Turner
13b. MOTHER'S MAIDEN NAME: Maria Richardson
14. NAME OF HUSBAND OR WIFE: Lillie Turner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service): No X X X
16. SOCIAL SECURITY NO.: 490 09 1423
17. INFORMANT Address: Lauren R. Turner 35th Crysler, Indep

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute pyelonephritis	7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebrovascular thrombosis	10 day
DUE TO (c)	Arteriosclerotic cardiovascular disease	Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept. 8, 1960 to Sept. 29 1960 and last saw him alive on Sept. 19, 1960
Death occurred at 3:05 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harold W Kearns M.D
22b. ADDRESS: 10901 W minis Rd, Independence
22c. DATE SIGNED: 9/22/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9 22 60
23c. NAME OF CEMETERY OR CREMATORY: Floral Hills
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS K.C. Mo: Floral Hills Mem. Chapels, Inc
25. DATE RECD. BY LOCAL REG.: 9-22-60
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

SEP 28 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Forrest D. Coldsmo

Licensed Embalmer No. 471

P. O. Address K. C. M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure t
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.